JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DEPARTMENT OF LABOR & ECONOMIC GROWTH
KEITH W. COOLEY, DIRECTOR

KEN ROSS
ACTING COMMISSIONER

Ingham County Circuit Court Case No.07-1211-CR

For Office Use Only:
Date Proof Received:_____
Proof of Claim #:_____

PROOF OF CLAIM

NATIONAL FOOT CARE PROGRAM, INC. (IN LIQUIDATION)

DEADLINE FOR FILING: JUNE 14 , 2008

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM. EACH SECTION MUST BE FULLY COMPLETED. INSTRUCTIONS ARE ATTACHED. IF ADDITIONAL COPIES ARE NEEDED, PLEASE PHOTOCOPY OR DOWNLOAD FORM: www michigan.gov/ofis, click on the Office of Financial and Insurance Services, then click "Who We Regulate", then "National Foot Care Program", then Proof of Claim Form. FILE A SEPARATE PROOF OF CLAIM FORM FOR EACH UNRELATED CLAIM.

PERSON OR ENTITY MAKING CLAIM AGAINST NATIONAL FOOT CARE PROGRAM , INC.:

1. NAME:_____
2. MAILING ADDRESS:_____
4. TELEPHONE NUMBER (DAYTIME): _____
5. **CLAIM IS FROM: (Check "X" or specify below)**

   A. ( ) Provider - Provide Federal Tax ID No. or National Foot Care Program ID No:_____

   Providers Note: Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see Proof of Claim Instructions.

   B. ( ) Member - Social Security No. of Payee_____

   Member ID Number_____

   C. ( ) Trade Creditor for amounts owed on open account - Social Security or Federal Tax I.D. No:_____

   D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No. :_____

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. **NUMBER OF CLAIMS: _____ AND TOTAL AMOUNT OF YOUR CLAIM**: $_____. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on charges. You may amend your timely filed claim up until the final date that your claim is adjudicated. Please attach all documents, contracts and invoices supporting your claim. If they are voluminous, please attach a summary.
8. No part of the debt has been paid, except_____
9. There are no setoffs, counterclaims, or defenses to the debt, except_____
10. There is no security for the debt, except (identify the security and the amount secured)_____
11. Legal and factual basis for any claimed right of priority of payment:_____

The undersigned claimant affirms that the representations and information contained in this Proof of Claim are true and correct to the best of his, her, or its knowledge and that the claimed debt is justly owing. The claimant further understands that any statements or representations contained herein which knowingly present a false claim constitutes a criminal offense punishable under Michigan Law.

Dated:_____

_____
Claimant's Name (please print or type)

Signature_____

Claimants Attorney (if any):_____

Title (if applicable)_____

SEE INSTRUCTIONS TO COMPLETE AND SUBMIT THE PROOF OF CLAIM FORM